1963

K.O. POLIO PROGRAM FOR UTAH

(PLEASE PRINT)

UTAH STATE MEDICAL ASSOCIATION

List on this form the names and ages of all persons in your household who appear at the clinic at the same time for vaccination.

CLINIC DATE: _____

HOUSEHOLD ADDRESS: _____

CITY _____ COUNTY _____

LAST NAME	FIRST NAME	INITIAL	AGE

I hereby request that Sabin Oral polio vaccine be administered to above listed minors:

SIGNATURE _____

RELATIONSHIP

FILL OUT and bring with you to polio clinic!